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Watkins, Sarah; Dewar, Belinda; Kennedy, Catriona

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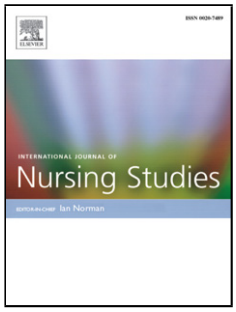

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Author: Sarah Watkins Belinda Dewar Catriona Kennedy

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Appreciative Inquiry as an intervention to change nursing practice in in-patient settings: an integrative review

Sarah Watkins a,*, Belinda Dewar b Catriona Kennedy c

a Nurse Researcher, Emergency Department, University Hospital Limerick, Ireland
b Professor of Practice Improvement, School of Health Nursing and Midwifery, Institute of Healthcare Policy and Practice, University of the West of Scotland
c Professor of Nursing, School of Nursing and Midwifery, Robert Gordon University, Aberdeen, Scotland

*corresponding author:
Ms Sarah Watkins Emergency Department,
University Hospital Limerick,
Limerick
Ireland
Tel 061482567 Email address: sarah.watkins@hse.ie

1.0 Introduction

1.1 Background

Contemporary nursing has hit the spotlight. Reports such as Francis (2013) catalogue many failings, not least a widespread acceptance of poor standards and nurses' apparent indifference to human suffering and distress. The limitations of traditional methods of managing healthcare are stark and it is clear that the needs of both patients and healthcare staff are not always being met (Trajkovski *et al.* 2013a). For example, Kirkup (2015, p. 17) highlights a culture of deeply entrenched patterns of 'defensiveness, denial and blame shifting'. Evans (2014) ponders a fragmented, top down management approach and an environment that is angst ridden and persecutory. Nurses must be supported to develop a questioning mindset to 'craft an ever more comprehensive context of understanding (Wall 2010, p.149) and to disrupt the 'widespread, thoughtless participation of nurses in future healthcare failings' (Roberts and Ion 2015, p.774). The urgent need to reframe nursing identity, phenomena and contribution within a 21st century health service has been recognised internationally (Scott *et al.* 2014). Emerging strategies speak of participation and collaboration and the collective merging of strengths and experiences in shaping transformation and positive change (Kings Fund 2015). There is a growing appetite for frameworks that emphasise the relational aspects of healthcare (Wyer *et al.* 2014). The message in modern healthcare is to reform and transform by thinking differently (Ham 2014) and by embracing innovative and disruptive interventions that challenge defensive and destructive practices.

The literature to date has not explored the utility of Appreciative Inquiry as a methodology to investigate, develop and change nursing practice in in-patient settings. Appreciative Inquiry promotes a new way of thinking and may lead to 'congruence between espoused values and practices' (Kavanagh *et al.* 2008, p.43). Espousing values of caring and excellence is one

thing but demonstrating this in a complex healthcare environment can be challenging (McSherry *et al.* 2012). Appreciative Inquiry may offer opportunities for attaining high quality practice by encouraging excellence in being responsive to complexity and embracing 'innovative and entrepreneurial' frameworks for care (McSherry *et al.* 2012, p.7). Appreciative Inquiry is described as a collaborative approach to the exploration and development of practice that is informed by consideration of what is working well (Reed 2010). Sharing and celebrating the good things in nursing can lead to a shift in perceptions of poor quality care (McSherry *et al.* 2012). Appreciative Inquiry calls for collective envisioning and engagement in meaningful dialogue (Reed 2010). This is important since 'liberating nurses to innovate and enhance practice' is reliant on an organisational culture that values people, welcomes disruption of ritual and routine and is receptive to new ways of thinking and doing (McSherry and Douglas 2011, p.166). Notably, Appreciative Inquiry promotes strategies that build the 'capacity to challenge the guiding assumptions of the culture, to raise fundamental questions regarding contemporary social life, to foster reconsideration of that which is taken for granted and thereby furnish new alternatives for social actions (Gergen 1978, p.1346).

2.0 What is Appreciative Inquiry?

2.1 Origins and Core Concepts

Appreciative Inquiry is associated with increasing efficiency and performance in the North American business sector. Originally conceived by Cooperrider and Srivasta in 1987 to serve as an adjunct to enhancing Action Research (Van Der Haar and Hosking 2004), Appreciative Inquiry has since been embraced as an instrument of change by large corporations such as NASA and McDonalds. More recently, Appreciative Inquiry has been adapted and used in the healthcare context. Appreciative Inquiry is underpinned by a set of five core principles (Table 1) and is defined as the:

'Co-operative, co-evolutionary search for the best in people, their organisations and the world around them. It involves systematic discovery of what gives life to an organisation or a community when it is most effective and most capable in economic, ecological and human terms' (Cooperrider and Whitney 2005, p.8).

Table 1 Five Core Principles of Appreciative Inquiry

Principle
Constructionist: Reality is created in communications, words and dialogue with others. Narrative is a stimulus for change.
Simultaneity: Change begins in the first questions asked. Change and inquiry are interdependent.
Poetic: The organisation should be viewed as an open book. Words, sentiments and topics are co-authored. In reframing and diverse interpretation there is a basis for creativity and innovation.
Anticipatory: Fuelling vibrant discourse and the collective imagination directs the function, achievement and aspirations of the organisation and those who work in it.
Positive: Positive imagery has a therapeutic effect. The higher the expectation of each other the greater the cognitive function and performance.

Integration of the five core principles of Appreciative Inquiry is necessary in the transition from a 'problem centric' to a 'possibility centric' organisation (Bushe 2011). Firstly, the Constructionist Principle states that human knowledge and organisational destiny are interwoven. Organisations are living human constructions and for organisations to transform there must be a hunt for 'alternative conceptions of knowledge and fresh discourse in human functioning' (Cooperrider and Whitney 2005, p.14). The Simultaneity Principle states that inquiry becomes the Appreciative Inquiry intervention. The seeds of change are rooted in the things people talk about, in dialogue and in the things that inspire positive images of the future (Cooperrider & Whitney 2005). The Poetic Principle encourages re-consideration of the aims of an inquiry so that change does not become mundane and repetitive. The Anticipatory Principle focuses on the use of positive imagery as a stimulus for change – social systems naturally gravitate towards affirmative images or images of the system at its best. Lastly, the Positive Principle emphasises the utility of positive affect for building rapport and initiating sustainable change. Positive emotion lends itself to flexibility, creativity, and organisational resilience (Bushe 2011).

2.2 The 4D Cycle

The 4D Cycle (Figure 1) is the main intervention model associated with Appreciative Inquiry (Bushe and Kassam 2005). This consists of four phases: Discovery, Dream, Design and Destiny (Figure 1).

Discovery is a critical stage of the inquiry and involves collecting useful, strength-based data. Key steps include identifying stakeholders, choosing topics of interest and sharing values and experiences to provide a platform for future practice development. This phase draws on a range of methods including observation and interviews in the practice setting. Interview questions are strategic and must 'evoke a real personal experience and narrative story' (Cooperrider *et al.* 2008, p.107). The idea being that participants draw on peak experiences and what is working well to stimulate dialogue about future possibilities.

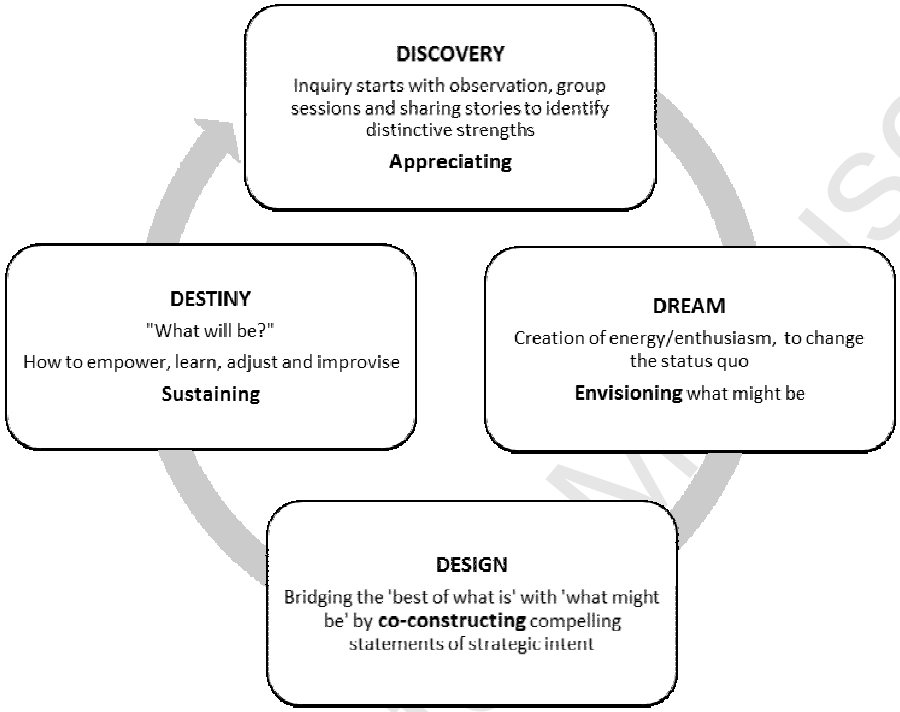
Dream searches for broad themes that emerge in the Discovery phase. Dream is about challenging the status quo and includes mapping of 'higher impact opportunities' (Cooperrider *et al.* 2008, p.133). This phase is about working closely with people leading to identification of common aspirations and a sense of how practice or the organisation should be shaped in the future.

Design focuses on developing the 'social architecture' or infrastructure that allows the organisation to make a dream the reality. It addresses those essential design elements that must be in place to facilitate this: leadership and management structures, systems, processes or policies, governance structures and relationships both internal and external (Cooperrider *et al.* 2008, p.163).

Destiny brings to the fore the preconditions necessary for transformation to happen. The organisation must be willing to move away from hierarchal control to facilitating individuals to innovate, to think outside the box. The goal is creation of a highly 'improvisational organisation' that acknowledges human capacity and genuinely embraces the principles of

participation so that individuals are inspired to meaningfully contribute. Crucially, there must be recognition of an organisation's positive core but also a commitment to challenging conventional practice (Cooperrider et al. 2008, p. 205).

Figure 1 4D Cycle



In using the 4D Cycle there can be integration of metrics for measurement, standards and benchmarks as there would be in standard organisational design. The difference with Appreciative Inquiry is that the starting point is an emphasis not on deficits but on what is working well (Cooperrider et al 2008). However, it is the transformative and energising potential of Appreciative Inquiry that makes it distinct from other change management strategies and may explain why healthcare researchers are drawn to using it (Ruhe *et al.* 2011). The drive to transform healthcare is panoramic. The antecedents and consequences of radical change, how to develop sufficient readiness and the means of judging whether the change that has occurred is truly transformational is less conspicuous (Lee *et al.* 2013). In appraisal of Appreciative Inquiry Bushe and Kassam (2005) focus on transformative change

since the dominant claim of Appreciative Inquiry proponents is that organisational transformation is possible in deployment of it. In examination of 20 cases of Appreciative Inquiry interventions to 2003, 35% achieved transformational outcomes (Bushe and Kassam 2005). Review of the extant literature led to construction of an appraisal tool by Bushe and Kassam (2005) in an attempt to make the constructs necessary to induce transformative change more tangible (Table 2). Transformation is possible when the Appreciative Inquiry process incorporates the core principles and the 4D Cycle, changes background assumptions, generates new knowledge that causes a radical shift in how things are done and creates a platform to enable diverse groups to circumnavigate conflict to move forward (Bushe and Kassam 2005).

Table 2 Appraisal Tool (Bushe and Kassam 2005)

Summary of the variables for appraisal
1 Transformational – exhibiting a shift in the state of being or identity of the system.
2 Outcome has new knowledge or new process where knowledge is a new realisation or considering what was previously impossible.
3 Intervention created a generative metaphor or a common reference point that guided participants.
4 Intervention adhered to the five core principles (Table 1).
5 Intervention followed the 4D cycle.
6 Intervention began with collecting stories of the affirmative topic.
7 Intervention helped to construct new ground where ground implies creating or changing background assumptions.
8 Intervention concluded with implementation (specific tangible change as agreed by consensus with a focus on the end result) or improvisation (numerous, diverse ideas for change being pursued by various actors).

2.3 Appreciative Inquiry in nursing

Arguably, this approach has relevance in a nursing context. For example, stimulating positivity is reputed to enhance disciplinary resilience by unlocking predispositions to act for the benefit of others and by increasing the social connection within the organisation (Cameron 2008, p.13). Appreciative Inquiry may assist with greater understanding of group

dynamics and the inherent anxieties that pervade nursing work, In nursing, social defences and attitudes are oftentimes deeply entrenched (Menzies-Lyth 1959, Goodman 2014, Kirkup 2015). The anticipated benefit in using Appreciative Inquiry for nursing practice is that whilst distinctive strengths are identified, damaging dynamics are also exposed and confronted. Deconstruction of maladaptive and potentially destructive behaviours opens the gateway for a type of practice that starts not by fault finding and apportioning blame but by building upon strengths and prompting a re-thinking of interactions (Reed 2010). Indeed, the perceived resonance between this methodology and the values and principles of modern nursing practice is seen to provide a platform to augment values and spearhead change (Reed 2010). Recent proliferation of negative accounts of nursing has become the catalyst for seeking change and alternative frameworks for care. Appreciative Inquiry offers potential as a new intervention approach to tap into core motivations, strengths and values that inspire and provide an impetus for change (Ruhe *et al.* 2011).

2.4 Aim

The aim was to find out what the published literature tells us about the impact of Appreciative Inquiry on changing clinical nursing practice in in-patient settings.

2.5 Objectives

- To identify how Appreciative Inquiry has been used in clinical nursing practice.
- To examine the use of Appreciative Inquiry as a paradigm for change.
- To examine the factors that impact on the implementation of Appreciative Inquiry.
- To gain understanding of the nature of change that has occurred by using criteria for judging transformation.

3.0 **Methods**

An integrative review of the literature was conducted. This approach summarises past empirical and theoretical research and provides greater understanding of a particular phenomenon of interest to nurses and other healthcare professionals. The integrative review permits a combination of diverse methodologies and provides opportunity for presentation of panoramic perspectives. The review was guided by the Preferred Reporting Items for Systematic Reviews (PRISMA) guidelines. These guidelines are endorsed internationally as an effective method of assessing the completeness of the reporting of systematic reviews. The PRISMA guidelines also have a utility for the reporting of other types of research including the evaluation of an intervention (Moher *et al.* 2009). PRISMA offers specific instruction as to how the title, abstract, introduction, methods, search strategy (Figure 2), results and discussion should be structured in a systematic review.

3.1 Sample and inclusion/exclusion criteria

In keeping with the aims of the review, the focus was on original research using Appreciative Inquiry methodology and integrating the 4D cycle. The 4D cycle was included as a criterion because it was deemed by experts (Bushe and Kassam 2005) to be an indicator of quality in an Appreciative Inquiry intervention. The 4D Cycle is seen to be critical in the strategic engagement of stakeholders and is fundamental to giving structure to the progress of the inquiry. Without it, there may be omission of or lack of attention to key steps in the organisational analysis which could affect the potential for transformation (Cooperrider et al 2008). Given the proliferation of reports of substandard hospital based nursing care, the aim was to identify, evaluate and synthesise the evidence about the impact of Appreciative Inquiry on changing clinical nursing practice in an in-patient context. Participants included nurses of all grades, patients, carers, relatives, other healthcare professionals including allied

healthcare staff, management and students as the intervention may pertain to enhancement of communications, interprofessional working, culture change, human interactions, clinical pathways and processes or the relational aspects of care. Studies were sought from in-patient settings in any country. Opinion papers, editorials, discussion papers, policy statements, research thesis, dissertations and literature review papers were excluded.

3.2 Literature search

Online databases were searched for items in English, published in peer reviewed journals from January 1990 (when Appreciative Inquiry started to appear as a methodology) to July 2015. A search of the following databases was conducted in Mar 2015 and updated in July 2015: Cumulative Index of Nursing and Allied Health Literature (CINAHL), MEDLINE, Cochrane Library (Cochrane Database of Systematic Reviews), Embase, PsychINFO, PsychARTICLES, ASSIA, AMED, Scopus and Web of Science (Table 3). Search terms included Appreciative Inquiry, Appreciative Action Research, 4D Cycle, Nurs*, practice development, change management, healthcare and use of the Boolean operators AND/OR.

Table 3 Initial search results

Scopus	550
MEDLINE	138
CINAHL	163
Embase	163
Cochrane Library	2
PsychINFO	378
PsychARTICLES	5
AMED	7
ASSIA	85
Web of Science	335

3.3 Search outcome

Initial searches resulted in 1826 records being identified. After duplicate removal using Endnote bibliographic referencing system, 928 remained. A total of 928 records were screened by the author and at least one other member of the review team. Screening the titles excluded 791 records with a further 113 records excluded after scanning the abstract. 24 full

text articles were assessed for eligibility. 13 of these were excluded because there was poor integration of the 4D cycle as it pertained to the study. Eight studies (11 articles) were included in the qualitative synthesis (Figure 2). One author (SW) undertook the search. The three authors (SW, BD, CK) determined the eligibility of studies for inclusion in the review.

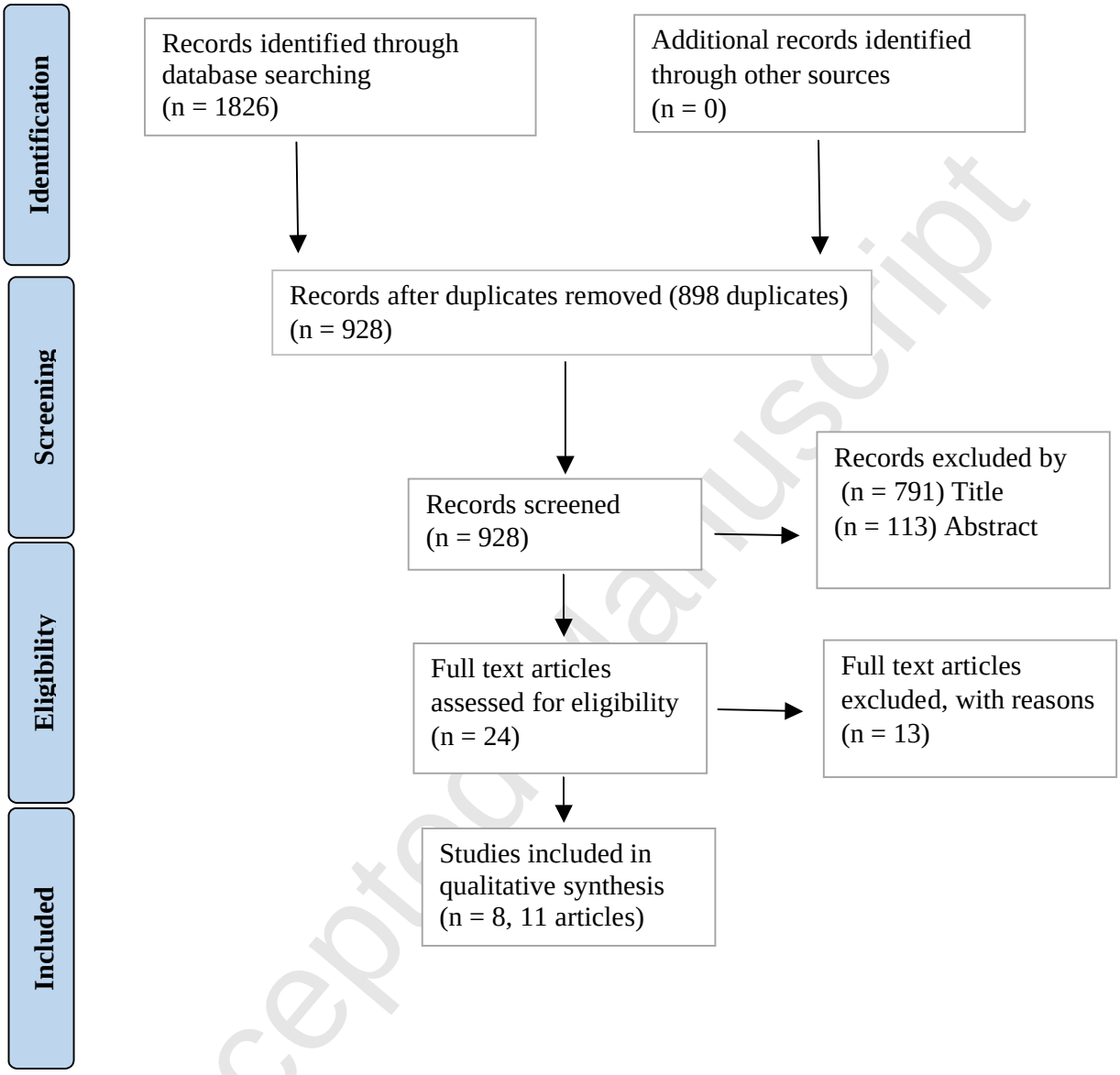
3.4 Data extraction and evaluation

The first author of this paper (SW) independently screened all titles and abstracts for inclusion. The two remaining authors (BD and CK) each reviewed half of the search results. Discrepancies were resolved by consensus or arbitration. Full texts retrieved were assessed against inclusion criteria and the team met in a one day data analysis clinic to agree final inclusion of the papers. Data was extracted using a standardised data extraction instrument incorporating the constructs of the appraisal tool (Table 2) as devised by Bushe and Kassam (2005) and the SIGN level of evidence classification system. Extracted information included: aims, study design, care setting and country, method, sample characteristics, approach to data analysis and interpretation, impact and nature of change (Table 4).

3.5 Data analysis

All coding summaries were discussed at team meetings to refine coding and to facilitate interpretation of the coded data. Synthesis was narrative using a four step approach and involved preliminary synthesis and explanation of the characteristics and findings of included summaries using tabulation and thematic analysis and in relation to the review objectives. Why Appreciative Inquiry worked in some cases and not in others was extrapolated. There was assessment of the robustness of the synthesis with reference to methodological quality, credibility, clarity and transparency of description.

Figure 2 Outline of search strategy



4.0 Findings

4.1 Summary of study characteristics

A summary of the eight single site studies meeting the inclusion criteria are presented in Table 4. Publication years for selected studies ranged from 2007 to July 2015. Study design was not identified in Clarke *et al.* (2012), Shendell-Falik *et al.* (2007) and Lazic *et al.* (2011). Methods in the main consisted of focus groups and structured interviews and thematic analysis by researchers. Five studies (Shendell-Falik *et al.* 2007, Kavanagh *et al.* 2010,

Lazic *et al.* 2011, Yoon *et al.* 2011, Clarke *et al.* 2012) involved the implementation of best practice standards to support nurse education, patient handovers, pain management practice and oral care service delivery. Sidebotham *et al.* (2015) examined midwives' perceptions of their role in the aftermath of recent reforms, Trajkovski *et al.* (2015a) focused on enhancing family centred care. Dewar and Nolan (2013) explored developing compassionate relationship centred care in an acute healthcare setting. Care settings were diverse and included paediatrics, acute medicine and midwifery. Participants in the main were nurses (Shendell-Falik *et al.* 2007, Kavanagh *et al.* 2010, Lazic *et al.* 2011, Yoon *et al.* 2011, Sidebotham *et al.* 2015).

Only one study, Dewar and Nolan (2013) achieved transformation. New knowledge led to a new process and the 7Cs model (being courageous, connecting emotionally, being curious, collaborating, considering other perspectives, compromising and celebrating) to support compassionate relationship centred care in everyday practice. Normative practices and behaviours were challenged so that this Appreciative Inquiry led to a new way of doing things. Trajkovski *et al.* (2015a) increased awareness of the impact of nurses' behaviours on parent well-being. The collaborative nature of workshops led to formation of trusting relationships and was said to have triggered positive self-reflection from nurses. Sidebotham *et al.* (2015) provided insight into the difficulties that midwives have in asserting their contribution and standing within the service. Midwives capacity for optimal care giving was restricted by 'internal dissension' and institutional processes.

Clarke *et al.* (2012) demonstrated that structured handoffs minimise the risk of harm to patients. The study provided an opportunity for staff to share ideas about improving care and led to the introduction of a standardised verbal report and transfer checklist. Staff appreciated the democratic nature of the inquiry that produced an action plan to improve pain management practices (Kavanagh *et al.* 2010) There was a realisation of the need to

capitalise on local human resources to engender change in long term sustainable interventions. In Shendell-Falik *et al.* (2007) similarly to Clarke *et al.* (2012), there was increased awareness of the danger of substandard handovers. Participants agreed that staff morale had improved with enhanced communication and a strengthening of rapport. Lazic *et al.* (2011) highlighted that the apprenticeship style of information exchange between nurses was not working. The study contributed to improvement in nurses' knowledge base and skills. This had a positive effect on the relationships between doctors and nurses. In Yoon et al (2011) participants valued the implementation of a validated assessment tool, greater organisational facilitation and the promotion of interprofessional teamwork as strategies for improving oral health care. The Appreciative Inquiry intervention in this case heightened the awareness amongst nurses of their role in initiating change. Three themes were inductively derived from the findings of included papers in this review: Appreciative Inquiry as an inclusive and democratic process, Appreciative Inquiry as a knowledge translation strategy and Appreciative Inquiry facilitation and sustaining change. The three themes are discussed below.

4.2 Appreciative Inquiry as an inclusive and democratic process

In all of the included studies Appreciative Inquiry was acknowledged by participants as a democratic and inclusive process. The participants who were nurses, nurse leaders, patients, family members, ward clerks and allied health care professionals, welcomed the opportunity to get involved in a positive and interactive form of communication (Lazic *et al.* 2011). Appreciative Inquiry was considered a refreshing contrast from hierarchal change management and education frameworks (Kavanagh *et al.* 2010, Yoon *et al.* 2011). Appreciative Inquiry demonstrated utility as a research and process improvement methodology (Clarke *et al.* (2012). In using Appreciative Inquiry there was trust, dialogue, teamwork and eradication of mistrust (Shendell-Falik *et al.* 2007, Trajkovski *et al.* 2015a).

The attention to strengths was considered uplifting as was the opportunity to openly celebrate what was working well (Dewar and Nolan 2013). Only Sidebotham *et al.* (2015) expressed disappointment at the outcome of Appreciative Inquiry because it did not produce 'positive solution focused dialogue' (p. 8). Bushe (2001) discusses the use of appreciative inquiry with different groups and suggests that transformation is more likely if there is a good social fit between the aspirations of the group and the ideals of the organisation. In Sidebotham *et al.* (2015) there is a clear dichotomy between midwives who would like to offer a midwifery service on their terms and organisational reforms that aspire to different ways of working to achieve continuity of care for child bearing women. In this case, the skill of the researcher in facilitating Appreciative Inquiry is unknown. This might be a factor in being unable to penetrate a 'mood of negativity and disenchantment' (Sidebotham *et al* 2015, p. 7). Despite the pervading negativity, a number of participants in this study expressed a wish to continue an experience that they found "cathartic".

4.3 Appreciative Inquiry as a knowledge translation strategy

In two Canadian studies (Kavanagh *et al.* 2010, Yoon *et al.* 2011), Appreciative Inquiry was used as a knowledge translation intervention. Knowledge Translation was depicted as 'a dynamic and interactive process that includes synthesis, dissemination, exchange and ethically sound application of knowledge to improve the health of Canadians' (Kavanagh *et al.* 2010 p.1). Knowledge Translation is said to boost the utilisation of research evidence by practitioners. In Kavanagh *et al.* (2010), Appreciative Inquiry addressed the contextually based impediments to promoting research evidence into practice. Although not explicitly stated, it seems that in a further three studies (Shendell-Falik *et al.* 2007, Lazic *et al.* 2011, Clarke *et al.* 2012) Appreciative Inquiry was used for similar purposes. For example, in Shendell-Falik (2007) and Clarke *et al.* (2012), participants enthusiastically engaged in a

quality improvement process that synthesised and disseminated best evidence to standardise patient handovers.

4.4 Appreciative Inquiry facilitation and sustaining change

In the main, the 4D cycle was rolled out and completed during workshops, sessions or modules of short duration (Table 4). In Dewar and Nolan (2013) was a year- long clinically based project where the researcher became immersed in the day to day activities of the people and setting. In Lazic *et al.* (2011) there was a preparatory phase of six months duration to assist participants to become familiar with the concept of Appreciative Inquiry and to choose a project of interest. The project itself was conducted for a year. How much time was spent in the clinical areas wasn't stated. Professional consultancy and external facilitation was reputed to be pivotal to the successful deployment of the Appreciative Inquiry intervention. In Kavanagh *et al.* (2010) the 'process facilitator' was essential in the provision of information and in conveying the core tenets of the methodology in a manner that was understood by all. Sidebotham *et al.* (2015) proposed that effective Appreciative Inquiry was contingent on the skills of the facilitator – the inference being that the inexperience of the facilitator in this Appreciative Inquiry may have weakened the power and potency of the intervention. Maintaining and sustaining change was a concern of many of the studies. Kavanagh *et al.* (2010) remarked that the lack of organised follow up post implementation of changes was a significant impediment to participants' long term commitment and motivation. Similarly, Yoon *et al.* (2011) observed that the commitment and impact of changes wasn't 'captured' beyond the two month appraisal. In Lazic *et al.* (2011) the enthusiasm for maintaining change 'dropped off' when staff realised the level of work and commitment involved. In Shendell-Falik *et al.* (2007) the impact of the Appreciative Inquiry was expressed in terms of immediate and short term outcomes.

Table 4 Characteristics of Appreciative Inquiry studies

Study	Aim	Method	Sample	Context	Approach to data Analysis/interpretation	Impact	Nature of change
Sidebotham et al (2015)	To examine midwives perceptions of their role amid health service reforms aimed at providing greater continuity of care.	Focus groups, open discussion/debate, field notes, audio recording and transcription of interviews.	23 midwives including 1 male	3 maternity units in Southeast Queensland	Iterative thematic analysis to identify empirical codes and to examine relationships to find meaning within and across the data.	A qualitative descriptive study that highlighted that midwives were disillusioned with their current working conditions.	No change in perceptions, behaviours or practice of midwives. Appreciative Inquiry was seen to have failed because it did not produce positive solution focused dialogue.
Lazic et al (2011)	To explore and develop collaborative working between doctors and nurses To develop an education programme for nurses.	Not stated explicitly but possibly questionnaires.	Age, education and number of nurses in the unit is given. Study sample size is not stated.	Haematology And Oncology unit for children in Serbia.	Not stated.	Improvement in knowledge of nurses. Improvement of interdisciplinary relationships.	Implementation of a task orientated education programme for nurses. No evidence of culture change or sustainable change in beliefs and practices.
Yoon et al (2011)	A knowledge translation initiative to improve oral care service delivery	2 modules or sessions of 10 hrs duration, questionnaire, elevator speeches, notetaking, transcription of dialogue and other subtleties by a research assistant.	9 nurses including 7 registered practical nurses and 2 RGNs.	Complex care rehabilitation unit for patients with stroke, neurodegenerative disorders and head injury in Toronto.	Content analysis of transcripts with identification and interpretation of dominant themes.	Development of a policy to ensure compliance with best practice in oral care delivery by nurses.	Implementation of best evidence to improve the technical aspects of oral care hygiene. No evidence of change in normative practices or behaviours.
Kavanagh et al (2010)	To determine acceptability/feasibility of Appreciative Inquiry. To develop an action plan to enhance evidence based pain assessment documentation.	4 sessions over two weeks each lasting 3hrs, digital recording, semi-structured interviews, transcription, group and facilitator logs.	3 nurse leaders 9 staff nurses	Paediatric surgical unit in Canada.	Descriptive statistics, qualitative content analysis	Development of an evidence based action plan to improve pain assessment and documentation.	Implementation of best evidence. Specific emphasis on short term improvement in existing practices therefore no change in culture or normative practices within the unit.
Clarke et al (2012)	To improve patient transfers to other units to protect patients against the risk of omission of important information during this process.	Semi-structured interviews, a workshop, concept mapping, brainstorming, storyboards.	29 RGNs 5 ward clerks 2 home care co-ordinators 9 allied health clinicians 2 patients 1 family member	4 acute general medical units in a Canadian tertiary teaching hospital.	Not explicitly stated. Thematic analysis	Development of a standardised verbal report and transfer checklist.	Implementation of best practice standards to support patient transfers. Emphasis on technical aspects with no change in culture or normative practices or behaviours within the units.

Table 4 Characteristics of Appreciative Inquiry studies

Study	Aim	Method	Sample	Context	Approach to data analysis/interpretation	Impact	Nature of change
Trajkovski et al (2013, 2015)	To enhance family centred care in a neonatal intensive care unit.	1 day workshop, audio recording, observation, focus groups, interviews, digital recording of group discussions, small group work, large group sessions, field note taking.	9 nurses 6 parents	Neonatal intensive care unit Sydney Australia.	Inductive thematic analysis with clarification and refinement of ideas by participants.	Development of a strategy to support family centred care in the unit.	Implementation of best practice standards. Increased awareness of the impact of nurses' behaviours on parents. No evidence of culture change or change in normative practices and behaviours.
Shendell-Falik et al (2007)	To improve nursing handovers between the emergency unit and telemetry unit.	Interviews where nurses from both units interviewed each other across departments, workshop, storyboarding, skits, roadmapping.	Nurses – number of participants not specified.	Emergency department and telemetry unit in the United States of America	Not stated explicitly. Thematic analysis of interview content by researchers and staff from both units.	Improvement in the handover process between both units. Better collaboration.	Focus on implementation of best practice standards. Increased awareness of the impact of poor communication on patients. No evidence of culture change or change in normative practices, behaviours.
Dewar & Nolan (2013) and Dewar & Mackay (2010)	To explore, develop and articulate strategies to enhance compassionate relationship-centred care for older people	Collecting stories using emotional touchpoints, informal and structured observation, interviews, informal discussions, group interviews, photo elicitation.	nurses non- registered care staff allied health care professionals including medical staff 10 patients 12 family members	Acute medical ward caring for older people in Scotland	Immersion crystallization including reflecting back to participants, creative synthesis, corroboration of themes, sharing and analysis of emergent themes by researchers and participants.	Revealed new knowledge, both relational and personal. Subtle interactions were magnified, establishment of meaningful connections, deeper insight, challenge to existing practice and assumptions.	Transformational change. New knowledge led to a new process and new model to support compassionate relationship centred care in everyday practice. Normative practices and behaviours were challenged so that the Appreciative Inquiry led to a new way of doing things. Truly participatory since the model was conceived of the insight of patients, relatives and staff working together to make fundamental change.

5.0 Discussion

A major finding of this review is that there is limited application of Appreciative Inquiry principles overall with inconsistencies in the operationalisation and reporting. This makes judgements regarding the impact of Appreciative Inquiry in nursing difficult to pinpoint.

Nurse researchers are beginning to value the potential of Appreciative Inquiry across a broad range of contexts and settings (Havens *et al.* 2006). From a nursing perspective and as evidenced by studies in this review, Appreciative Inquiry is viewed as a participatory and exploratory process that presents nurses with an opportunity to develop 'effective social networks, high levels of engagement and interdisciplinary collaboration (Trajkovski *et al.* 2013b, p.98). Appreciative Inquiry is perceived as a refreshing contrast to the traditional deficits approach to change management. As a consequence, Appreciative Inquiry is determined to be more likely to engender trust and dialogue (Shendell-Falik *et al.* 2007, Trajkovski *et al.* 2015b). The blending of Appreciative Inquiry with Knowledge Translation is a lucrative one, leading to creation of new identities and communities of practice and greater collaborative functioning (Kothari and Wathen 2013). Appreciative Inquiry is complimentary to nursing, increasing the utilisation of research evidence and identifying impediments that may impede practitioners from disseminating and implementing research findings in daily practice (Kavanagh *et al.* 2010).

However, only one of the studies achieved transformation (Dewar and Nolan 2013). In this Appreciative Inquiry intervention there was creation of a safe place where members of staff dispensed with defensiveness. Co-participation of staff, patients and relatives led to development of a framework for practice that radically shifted how nursing was done. In relation to the remaining studies in this review, Appreciative Inquiry resulted in small changes in nursing practice and behaviour but radical change of the scale that Bushe and

Kassam (2005) describe was not achieved. As indicated in a proliferation of reports, future nursing practice requires change of greater magnitude if it is to expose and confront those dynamics that conspire to cause patient distress. Appreciative Inquiry seeks new alternatives for action and a type of change that transcends improvement in the existing process. Appreciative Inquiry provides a conceptual framework for critical analysis of important elements of the change intervention. This is what makes the Appreciative Inquiry process distinct from the standard quality improvement approach.

The 4D Cycle is the main intervention associated with Appreciative Inquiry (Bushe and Kassam 2005). It is the essential mechanism for addressing design elements that are pivotal to success in the Appreciative Inquiry process. Yet, many of the studies seemed to pay only limited attention to the objectives of the 4D Cycle which was generally rolled out in a series of workshops of short duration. This is in contrast to Dewar and Nolan (2013) who undertook a year - long clinically based project and became immersed in the context and activities of the setting. In the other studies in this review, the 4D Cycle appeared to be superficially applied so that it was difficult for the reader to get a feel for the imagery or the unique dialogue or the fateful questioning that would ultimately bring about radical change. There is mounting criticism of the implementation of a sanitised version of the now 'ubiquitous' 4D cycle. Interestingly, the 4D cycle, once the embodiment of Appreciative Inquiry runs the risk of being manipulated to become a reductionist, goals orientated structure (Kavanagh *et al.* 2010). Therein sits a precondition for a successful Appreciative Inquiry intervention. Rigid application of the 4D Cycle, a pervading willingness to conform and an emphasis on implementation of standards serves only to maintain the status quo. Crucially for transformation to occur the organisation must be willing to challenge conventional practice (Cooperrider et al. 2008, p. 205). The pre-defined scope of many of the studies was at loggerheads with the core ethos of Appreciative Inquiry that calls for improvisation by

'fabricating and inventing novel responses without a pre-scripted plan (Barrett 1998, p.608). Kavanagh *et al.* (2010) remark that it was easier to stick to implementation of a 'tailored action plan' than it was to risk disruption in trying something new (p.6). Barrett (2012) talks of the reluctance to disrupt in constraint and 'too much consensus' and forewarns that a reluctance to disrupt reduces the possibility for transformation.

Appreciative Inquiry literature is replete with reference to the concept of Transformation. As Bushe and Kassam (2005) see it, transformation is "a shift in the state of being or the identity of the system" (p.170). It may be that in a business context organisation wide transformation is more likely, given the custom of seminars and the seeming high rate of investment in professional facilitators. This is in sharp contrast to the realms of nursing, where the resource implications of systems wide change versus the paucity of funding in nursing research is challenging. Additionally, transformation in health care is rare because the 'institutional embeddedness of healthcare occupations and organisations' makes change of this magnitude difficult to attain (Lee *et al.* 2013, p.116). However, Ham (2014) discusses NHS healthcare strategy and draws attention to a ripple effect where localised network and micro system change is seen as the route to panoramic transformation. The inference then is that in nurturing multiple Appreciative Inquiry hotspots there is the chance of a small scale shift in the state of being and the prospect of a snowball effect in securing systems wide metamorphosis. Dewar and Nolan (2013) is an example of an Appreciative Inquiry hotspot. This intervention created a shift in the state of being, in the conduct of nursing and relationships on an acute medical ward for older people. Creation of more of the same in different clinical settings could possibly achieve the snowball effect that Ham (2014) speaks of.

Transformation then is not beyond the realms of possibility and the constructs as outlined by (Bushe and Kassam 2005) afford a level of tangibility. It makes sense and indeed nursing

would look very different, if there was a shift in background assumptions and the establishment of a collective platform to enable future discovery. It seems that part of the problem in achieving transformation using Appreciative Inquiry is in the detail. This systematic review has revealed an inattention to the nuances of the 4D Cycle and an apparent lack of cognisance of the core principles (Table 1). Part of the problem too is in the facilitation.

The importance of the facilitator in creating possibilities for sustainable change has been given prominence in many of the studies. Lack of expert facilitation in deployment of a complex, unknown methodology, might explain in part the apparent going through the motions of the 4D Cycle or the deficit of novel responses that was evident in the majority of studies in this review. Significantly, the only study to engender transformation was Dewar and Nolan (2013) and in this case the appreciative inquirer was an experienced facilitator and action researcher. A moot point is that if expert facilitation becomes a necessary precursor to the Appreciative Inquiry intervention this has implications for its use in nursing, especially in relation to the scarcity and cost of hiring a methodological expert.

6.0 Conclusion

The findings of this review suggest that Appreciative Inquiry offers potential for nurse practice development in strengthening relationships, eradicating defensiveness and shaping processes to enhance care for patients. However, there must be cognisance of the pivotal components. Successful Appreciative Inquiry demands prerequisite understanding. Primarily, complex adaptive systems are less responsive to imposed organisational design and in healthcare and as advocated by Appreciative Inquiry, interventions illuminating human perspectives and maximising the self - organising potential work best (Rouse 2008). Therein is a caution against the choreography of Appreciative Inquiry where participant experiences

or stories are moulded to fit an agenda or a previously drafted master plan. Throughout most of the studies the implementation of procedure and policy was overemphasised so that elements of participant inclusivity were almost lost. Appreciative Inquiry does not advocate being dismissive of the best evidence but rather places primacy on language and depth of human experiences, on observation and that type of evidence that is borne of generativity. The acquisition of nuanced understanding is unachievable within the confines of one and two day workshops. Furthermore, this is a methodology that is at odds with the mantra of reaching targets and yielding a quick fix. It is likely, given restricted healthcare budgets, that Appreciative Inquiry could be insufficiently resourced for some time to come.

The robust conceptual framework distinguishes Appreciative Inquiry from conventional organisational design and as a consequence there is a demand for high quality inquiry that is more engaged and rigorous (Reed 2012). Finally, healthcare literature is replete with reference to transformation, the exact components of which are difficult to capture. The constructs of transformation as determined by Bushe and Kassam (2005) provide a workable definition that is transferable across a plethora of domains. Greater understanding prior to beginning an Appreciative Inquiry would expand the scope for change that is truly transformational. Further research is required to examine the role of expert facilitation in ensuring the success of Appreciative Inquiry and in engineering transformational change.

Limitations

A decision was made to limit the review to studies that included the 4D cycle, as this is the main intervention model associated with it. However, the 4D cycle is increasingly being recognised as a reductionist, goals orientated structure where rigid application could be perceived as an impediment to successful outcomes in Appreciative Inquiry. Furthermore, the blending of Appreciative Inquiry with Knowledge Translation was seen to be beneficial in the dissemination, integration and utilisation of research evidence. This review might have benefited from looking at whether the chance of transformation was increased in blending Appreciative Inquiry with methodologies that are more familiar in a healthcare context. Narrowing the scope of the review to acute care settings may have reduced the possibility of finding successful Appreciative Inquiry interventions.

Recommendations

Further research is required to examine the impact of professional or expert facilitation on successful outcomes in Appreciative Inquiry.

Conflict of interest

None declared.

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2 What is already known about this topic?

- There is potential for transformation in using Appreciative Inquiry, hence the application of Appreciative Inquiry in a healthcare and nursing context is gaining momentum.
- There is a lack of cognisance of how to maximise the potential for innovation within Appreciative Inquiry and so 'lots of things' end up getting called Appreciative Inquiry. Arguably, this increases the risk of it being perceived as little more than a fad phenomenon.

3 What this paper adds

- Appreciative Inquiry provides a framework that holds exciting possibilities for nurse practice and development. The 4D Cycle is pivotal to the strategic success of the Appreciative Inquiry process.
- There are certain preconditions necessary to increase the possibility of achieving transformation using Appreciative Inquiry. Primarily, the organisation must be open and willing to challenge conventional practice. Secondly, expert facilitation was identified as a key factor in achieving successful outcomes using an Appreciative Inquiry intervention.